DOCUMENT RESUME

ED 440 345 CG 030 040

AUTHOR	Buck, Tina; Sales, Amos
TITLE	Related Addictive Disorders.
PUB DATE	2000-00-00
NOTE	13p.; In: Substance Abuse and Counseling; see CG 030 037.
PUB TYPE	Guides - Classroom - Teacher (052) -- Guides - Non-Classroom (055) -- Information Analyses (070)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	*Counseling Techniques; Counselor Training; Eating Disorders; Substance Abuse
IDENTIFIERS	*Addiction Counseling; *Addictive Behavior; Gambling; Sexual Addiction; Workaholism

ABSTRACT

This paper provides an overview of addiction related to substance abuse. It provides basic information, prevalence, diagnostic criteria, assessment tools, and treatment issues for eating disorders, compulsive gambling, sex addictions, and work addictions. Eating disorders such as anorexia nervosa and bulimia nervosa, especially affect adolescents. Addictions can be seen on a continuum from experimentation to dependence. It is important for counselors to be aware of the symptoms along this continuum. Many individuals with addictions adopt coping strategies by exchanging one addiction for another or by engaging in multiple addictive processes simultaneously. Individual therapy, group therapy, self-help group support, medications, exercise, nutrition, relaxation, recreation, spirituality, and healthy relationships are all critical factors in addiction recovery. It is important to engage family members in the client's recovery process for relapse prevention purposes. Also included is a facilitator's manual which is a practical guide for teaching content through guided experiential projects. Three objectives are listed, and three student exercises are provided. (Contains 24 references.) (MKA)

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Related Addictive Disorders

Tina Buck & Amos Sales

Introduction

The term "addiction" has taken on a broader meaning in western culture since the founding of Alcoholics Anonymous (AA) in 1935. From that date to present, numerous self-help recovery groups have evolved to assist individuals in dealing with various addictive disorders and issues other than alcohol or drugs. Examples include church-related support groups, Overeaters Anonymous, Bulimorexics Anonymous, Sex Addicts Anonymous, Co-Sex Addicts Anonymous, Sex and Love Addicts Anonymous, Gamblers Anonymous, Gamanon, Workaholics Anonymous, and Debtors Anonymous. Yalom (1995) reports from a 1991 Gallup Poll that 40% of the United States population, age 18 and over, is seeking therapeutic help through these types of self-help groups. Terms from these self-help groups have become common household terms and are regularly used by the media. Treatment centers have expanded to treat these other addictive processes, often referred to as "process addictions" (Donovan, 1988). A legitimate concern is that the term "addiction" has become overused and limits human potential through labeling and deferring responsibility.

Addictions related to substance addictions can be identified when individuals exhibit behaviors typically associated with addiction as follows: (1) preoccupation with the substance or activity; (2) withdrawal symptoms after not engaging with substance or activity; (3) increased tolerance for the substance or activity in order to achieve the same effect; and (4) continued use despite negative consequences. What are often misunderstood and disregarded are the incredible suffering and negative consequences of individuals, their loved ones, and society due to related addictive disorders. Therefore, counselors need to broaden their beliefs and perceptions regarding substance abuse to include behavioral addictions along the same continuum as substance abuse: experimentation to severe addiction. The purpose of this chapter is to provide an overview of the related behavior or process addictions most commonly represented in current literature and addressed in treatment. Diagnostic tools and other resources for counseling clients with behavior addiction issues will be addressed. Characteristics of eating disorders, compulsive gambling, sex addiction, and work addiction will be discussed and related diagnostic and treatment considerations identified.

For most addictions, the *Diagnostic and Statistical Manual, Fourth Addition (DSM-IV)* (APA, 1994) assessment criteria have been included, as it is the best resource for making an accurate assessment. The DSM-IV provides scales and questionnaires to assist in the diagnostic process, and some additional scales and questionnaires are included later in the chapter. It is possible that an individual's relationship or attachment to almost any activity or substance can become an addiction. Simple activity is not an addiction. One must look at the individual situation and make appropriate assessments of the biological, psychological, and sociocultural factors of each client. Assessments need to include ruling out psychiatric disorders such as bipolar disorder, depression, anxiety disorders, obsessive-compulsive disorder, obsessive-compulsive personality disorder, and other personality disorders. It is important to assess and to treat the whole person, or body/mind/spirit/environment/relationship aspects as they relate to the addictive process.

Eating Disorders

The three areas of eating disorders that will be covered in this chapter are anorexia nervosa, bulimia nervosa, and binge eating disorder. Research indicates that cultural expectations about body image, increase of body fat during puberty (Swarr & Richards, 1996), and relationships in early adolescence (Cauffman & Steinberg, 1996) are factors contributing to eating disorders. Studies show that 1% of all adolescent girls develop anorexia nervosa and 2%-3% develop bulimia nervosa (National Institute of Mental Health, 1996). Most individuals begin engaging in disordered eating behavior during adolescence, and the number of persons with anorexia nervosa and bulimia nervosa decreases with age. Self-esteem and self-worth are closely linked to body image, and depression is often present in individuals who are continually dissatisfied with their body image perceptions. Characteristics of persons with eating disorders include denial, control, manipulation, compulsive behaviors, sense of powerlessness, and obsessive thought patterns (National Institute of Mental Health, 1996). Cultural aspects of body image as well as level of acculturation with individuals from different ethnic populations are considerations. Le Grange, Stone, and Brownell (1998) report differences between White, Black, Asian, and

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Hispanic women: "More Black women were overweight and purged compared to the other groups. Asian women valued the beneficial role of exercise in weight control more, while Black women were more inclined to attribute weight gain to cravings and slow metabolism" (p. 1). History of sexual abuse is associated with eating disorders in one study (Deep et al., 1998): 23% of subjects with anorexia nervosa reported some form of sexual abuse in their history, as compared to 7% of controls. Also reported was that 65% of subjects with bulimia nervosa had substance abuse issues. Other risk factors for development of eating disorders include emotionally distant parental relationships (Swarr & Richards, 1996), excessive focus on body image through sports or modeling, and various forms of abuse and trauma.

Anorexia Nervosa

How thin is too thin? Our cultural expectations of beauty, youth, and "superwoman" traits are factors associated with the onset of anorexia nervosa, the delusional control of body weight and body image. It is estimated that 0.5% to 1% of the U.S. population meet the *DSM-IV* criteria for anorexia and that less than 10% with this disorder are male (APA, 1994). Some of the symptoms associated with anorexia are restrictive eating patterns, preoccupation with body weight and image and distorted body image, use of exercise and stimulant drugs to control body weight, and extreme fear of becoming obese. Clients with anorexia nervosa may engage in an obsession about body parts which they consider "fat", especially buttocks, abdomen, and thighs (APA, 1994). Physical symptoms associated with anorexia nervosa include emaciated physical appearance, electrolyte imbalance, amenorrhea, malnutrition, anemia, cardiac imbalances, physical sensitivity to cold, and general physical weakness.

The following are the *DSM-IV* criteria for Anorexia Nervosa (APA, 1994):

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type:

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas) (p. 544)

Bulimia Nervosa

Prevalence of bulimia is reported in the *DSM-IV* as 1 to 3% of young adults (APA, 1994). As compared to persons with anorexia, bulimia often presents in a more "normal" body weight range. Clients with bulimia will eat small to very large amounts of food followed by self-induced vomiting. Other forms of purging include use of laxatives, diuretics, enemas, and excessive exercise. A person with bulimia may use one or any combination of these purging techniques, and these may change over time. They can develop financial concerns due to the amount of money they spend on food as well as get into legal trouble by shoplifting or writing bad checks for food. Symptoms of bulimia include lengthy time spent in bathrooms, dental problems, teeth marks on the back of hands, rapid weight gain or loss, chronic sore throat, and depression.

The following are the *DSM-IV* criteria for Bulimia Nervosa (APA, 1994):

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   (1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
   (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Non-purging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas. (p. 549)

Binge Eating Disorder

By itself, compulsive overeating is not represented as a psychiatric disorder in the *DSM-IV*. Compulsive overeating can appear to be similar to substance addictions including symptoms such as secretiveness, isolation or both, while engaging in the behavior, inability to control behavior despite negative consequences and repeated attempts to gain control, obsession about the substance (food), social plans arranged around eating behaviors, and medical consequences. Clients with obesity do not necessarily engage in compulsive overeating and may have medical conditions that contribute to, or precede obesity. There are other forms of eating disorders along a continuum from overeating to starvation and counselors are advised to be familiar with different types.

The following are the *DSM-IV* criteria for Eating Disorder Not Otherwise Specified (APA, 1994):

The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific Eating Disorder. Examples include:

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa. (p. 550)

Treatment

It is important for counselors to be aware of the physical consequences of active eating disorders that can be significant and often require medical attention. Some physical consequences of anorexia and bulimia nervosa include problems with kidneys, liver, stomach, intestines, and heart; esophageal tears, swelling of parotid glands, dental problems, electrolyte imbalances, low potassium, malnutrition, anemia, dizziness and lightheadedness, thinning of hair, dry skin, sensitivity to cold, growth of fine body hair, amenorrhea, anxiety, depression, and increased risk for suicide. Physical consequences of compulsive overeating include obesity, stress on all major organs, stress on lower extremities, high cholesterol, diabetes, sleep apnea, anxiety, and depression. Surgical procedures such as liposuction, plastic surgery, and stomach staples may be used by persons with any type of eating disorder as a form of self-mutilation as compared to appropriate medical care.

When working with clients who engage in eating disorders, counselors can benefit from collaboration with other health care providers on behalf of the client. A treatment team can include a physician, psychiatrist, and nutritionist, who specialize in eating disorders and who utilize compatible approaches to treatment. Rigidity

about meal planning is not necessarily a healthy goal of treatment. An excellent assessment tool for eating disorders is the Eating Disorder Inventory 2 (EDI-2) (Western Psychological Services, 800-648-8857). For information regarding national certification for eating disorders, or other resources related to eating disorders, contact the International Association for Eating Disorders Professionals at 800-800-8126 or www.iaedp.com. Group support is important; however, it is important to recognize that specifically with eating disorders, referral to a 12-step program such as Overeaters Anonymous or Bulimorexics Anonymous is not always a good option because of mixed reactions to control and shame issues related to eating patterns for some individuals. For information on alternative non-12-step based support, a resource is Mirasol which can be contacted at 888-520-1700 or www.edrecovery.com. Another resource for information about eating disorders is *The Eating Disorder Sourcebook* (Costin, 1996).

Gambling

There has been an increase in gambling over the past 20 years with increased availability of casinos, state lotteries, and internet gambling sites. This trend will likely continue as states become reliant on gambling revenue from multiple sources. An estimated 1 to 2% of adults have gambling addictions that range from problematic to pathological (Lesieur, & Blume, 1993), with higher rates in states that have legalized gambling. Estimates of gambling among high school and college students range from 4 to 6% (Lesieur & Blume, 1993).

Pathological gamblers report feeling a "rush" while engaging in the "action" of gambling and may be oblivious to physical needs or social obligations while engaged in "action". This "rush" is associated with an increase of adrenaline and norepinephrine levels (Lesieur & Blume, 1993). Over half of gamblers report withdrawal symptoms (Shaffer, et al., 1989). Consequences of gambling are especially notable in financial loss, incarceration, stress related illness and depressive episodes with suicide ideation and attempts (Lesieur, & Blume, 1993). To get themselves out of trouble, pathological gamblers may turn to family members for "bailout" measures when they have exhausted all resources. Pathological gamblers have distorted thinking and may have superstitions that provide them with confidence for success. They believe that "...money is both the cause of and solution to all their problems" (APA, 1994, p. 616).

Lewis (1994) describes five factors associated with gambling:

(1) external locus of control;
(2) alternating periods of extreme confidence and extreme self-devaluation including polarized mood swings;
(3) underlying personality disorders including Antisocial Personality Disorder and Narcissistic Personality Disorder;
(4) preference for immediate gratification; and
(5) difficulty with intimacy in relationships.

Alcoholism and eating disorders also can be closely linked to pathological gambling (Lesieur, & Blume, 1993) and each of these addictions may interface with a stimulus, or "trigger", to engage in other addictions. Clearly, some of the symptoms of each also overlap, which can create difficulty in assessment and treatment of persons with combined disorders. The South Oaks Gambling Screen (SOGS) is a widely used scale to assist in assessment of gambling addiction (Leisier & Blume, 1988). The Gamblers Anonymous 20 questions are also a useful tool for assessment.

There are different types of gambling such as the following: casino, horse and dog track, stock market, commodities, sports betting, lottery, internet games, private card games, dice games, cockfights, as well as gaming practices in various ethnic groups. Gamblers may be engaged in a sub-culture complete with unique linguistics, rituals, and customs (Ocean & Smith, 1993). Symptoms of active gambling are secretiveness and excessive time with phone calls and internet access, unaccounted time away from work or home, unexplained preoccupation, increased debt and worry over finances, extravagant expenditures, and increased alcohol, drug consumption, or both.

The following are the *DSM-IV* criteria for Pathological Gambling (APA, 1994):

A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:
(1) is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)
(2) needs to gamble with increasing amounts of money in order to achieve the desired excitement

(3) has repeated unsuccessful efforts to control, cut back, or stop gambling
(4) is restless or irritable when attempting to cut down or stop gambling
(5) gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
(6) after losing money gambling, often returns another day to get even ("chasing" one's losses)
(7) lies to family members, therapist, or others to conceal the extent of involvement with gambling
(8) has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
(9) has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
(10) relies on others to provide money to relieve a desperate financial situation caused by gambling

B. The gambling behavior is not better accounted for by a Manic Episode (p. 218)

Treatment

Most of the initial treatment issues of compulsive gamblers are related to financial matters. Because the use of money is a daily experience, clients will need to be provided the structure and support to develop a new relationship to money. They will need to develop a financial plan including restitution, if needed. Additionally, providing structure for each day and cognitive restructuring for sensory stimulation that triggers compulsive urges would benefit the client. Gamblers Anonymous and Debtors Anonymous are resources for group support and can be found in most communities. The National Council on Problem Gambling can be contacted for information on state or national certification for counselors wishing to specialize in this area as well as for information on a wide range of gambling issues at 800-522-4700 or www.ncpgambling.org. Another resource for more information about problem gambling is Pathological Gambling: Conceptual, Diagnostic, and Treatment Issues (McGurrin, 1992).

Sexual Addiction

Secretiveness is paramount with any addiction; however, with the puritan cultural views on sexuality in our country, sex addiction carries with it an extreme amount of shame. Thus, the secret of sexual addiction often remains secret unless the counselor is skilled at interviewing and comfortable discussing these issues in order to set the client at ease. Rigid religious beliefs may make disclosure even more difficult. There does not seem to be estimates available for prevalence of sexual addictions, however it is notable that with the privacy of internet access in the home, it appears that sexual addiction is rapidly increasing in the United States. President Bill Clinton's affair with Monica Lewinsky brought national media attention to the idea that sexual addiction is present in our culture (Carnes, 1998); has predictable symptoms, is progressive, and may involve increased risk over time.

There are not yet *DSM-IV* diagnostic criteria available for forms of sexual addiction that do not involve harm to others. Forms of sex addiction that harm others do have *DSM-IV* categories and include exhibitionism, voyeurism, and pedophilia (APA, 1994). Goodman (1989) (as cited in Schneider, 1994) provides a good guide for client assessment regarding addictive processes when diagnostic criteria are not provided for in the *DSM-IV* criteria for diagnosing addictive disorders. At least three of the following criteria must be established in order for a diagnosis to be made:

1. Frequent engaging in the behavior to a greater extent or over a longer period than intended.
2. Persistent desire for the behavior or one or more unsuccessful efforts to reduce or control the behavior.
3. Much time spent in activities necessary for the behavior, engaging in the behavior, or recovering from its effects.
4. Frequent preoccupation with the behavior or preparatory activities.
5. Frequent engaging in the behavior when expected to fulfill occupational, academic, domestic, or social obligations.
6. Giving up or limiting important social, occupational, or recreational activities because of the behavior.
7. Continuation of the behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused or exacerbated by the behavior.

8. Need to increase the intensity or frequency of the behavior to achieve the desired effect, or diminished effect with continued behavior of the same intensity.
9. Restlessness or irritability if unable to engage in the behavior. (Schneider, 1994, p. 28)

It is recommended that counselors become familiar and comfortable with sexual terms to be able to work with clients who have sexual addictions. Indirect or judgmental statements can alienate clients and further add to the sense of shame associated with sexual addiction. Some common terminology is represented in examples of sexual acting out from Carnes (1991) as adapted by Schneider (1994):

1. Fantasy sex: neglecting commitments because of fantasy life, masturbation.
2. Seductive role sex: extramarital affairs (heterosexual or homosexual), flirting and seductive sex.
3. Anonymous sex: engaging in sex with anonymous partners, having one-night stands.
4. Paying for sex: paying prostitutes for sex, paying for sexually explicit phone calls.
5. Trading sex: receiving money or drugs for sex.
6. Voyeuristic sex: patronizing adult bookstores and strip shows, looking through windows of houses, having a collection of pornography at home or at work.
7. Exhibitionist sex: exposing oneself in public places or from the home or car, wearing clothes designed to expose.
8. Intrusive sex: touching others without permission, using position of power (e.g. professional, religious) to sexually exploit another person, rape.
9. Pain exchange: causing or receiving pain to enhance sexual pleasure.
10. Object sex: masturbating with objects, cross-dressing to add to sexual pleasure, using fetishes as part of sexual rituals, having sex with animals.
11. Sex with children: forcing sexual activity on a child, watching child pornography. (p. 29)

Additional forms of sexual acting out referred to as "cybersex" can be accessed by Internet. They include pornographic sites, virtual reality, and sexual chat rooms. One doesn't have to "surf the net" very long to find some of these sites. Electronic access to chat rooms also presents an avenue for love and relationship addiction.

Consequences of sexual addiction can include sexually transmitted disease, including HIV infection, involuntary sexual involvement, unplanned pregnancy, or physical harm from use of foreign objects. Individuals may neglect personal health and social obligations, and engage in a secretive cycle of sexual acting out. Variations on sex addiction can include sex, love, and relationship addiction in which an individual experiences a "high" from initial "falling in love" stages of relationships. Monogamy may or may not be a part of this kind of pattern.

Treatment

Treatment issues for sex addiction include assisting the client in identifying the range of environmental triggers as well as internal triggers. It is important to work with the client on shame reduction and strongly encourage group support for identification with others who have this addiction. The counselor needs to be aware of how to assist clients in developing different goals for clients on the engagement to abstinence continuum. Sex Addicts Anonymous can be contacted in most communities as a diagnostic resource for the *The Sex Addicts Anonymous Questionnaire*, and for client group support. Related support groups include Sexaholics Anonymous, Co-Sex Addicts Anonymous, and Sex and Love Addicts Anonymous. For national credentialing and other related information on sex addiction, contact The National Council on Sexual Addiction and Compulsivity at 770-989-9754 or www.ncsac.org. Another resource for information regarding sex addiction is *Don't Call it Love: Recovery From Sexual Addictions* (Carnes, 1991).

Work Addiction

There do not appear to be statistics indicating the prevalence of workaholism. Seybold & Salomone (1994) provide a summary from a review of the literature describing workaholic characteristics:

...an excessive commitment to work that is manifested by a neglect of other and important aspects of life–workaholism–has been described as the following:

(a) an "addiction" that is uncontrollable or

(b) an escape from personal problems, including the avoidance of intimacy with other persons. In addition, workaholism may be the result of

(c) a deep and pressing need to control one's life;
(d) an exceedingly competitive nature, often associated with a drive to succeed;
(e) an impaired self-image and limited self-esteem as a result of childhood traumas including poverty; and
(f) workaholic parents or role models. (p. 5)

These traits are similar to Type A or obsessive-compulsive characteristics, but seem to be directly related more to work than to other aspects of daily living. The Work Addiction Risk Test (WART) may be used as a scale to measure workaholism (Robinson, 1989).

It is clear that because of cultural rewards, some aspects of workaholism are promoted within western culture. Entire business structures may be based on work addiction that require executives and other employees to engage in workaholic behavior. This may seem familiar to many a reader as companies downsize/reorganize and reassign responsibilities. Those who produce, survive. So what defines workaholic behavior in comparison to solid, efficient, productive work? Again, the answer is not a simple one and it is the personality traits and negative consequences that seem to guide the definition. It is important to recognize that strong work ethic does not necessarily mean that someone has workaholism. As well as other addictions, there is a continuum from experimentation to dependence. It is important not to make assumptions about a person's relationship to their work without thorough investigation.

Scott, Moore, and Miceli (1997) describe three kinds of workaholism; Compulsive-Dependent Workaholism, Perfectionist Workaholism, and Achievement-Oriented Workaholism. According to their model, Compulsive-Dependent Workaholism seems to manifest as understanding of reasonable expectations; however, obsessive thoughts override healthy thoughts, and work is used as a coping skill to deal with those same obsessive thoughts. Perfectionist Workaholics display an unreasonable need for control and may perceive gain from attempting to control others in the work setting. Last, the Achievement-Oriented Workaholics, in an upwardly mobile style, "...always spend a great deal of discretionary time on work activities, constantly think about work, and work beyond employer and economic requirements" (Scott, Moore, & Miceli, 1997, p. 299). Potential consequences from workaholism may include fatigue, chronic illness, burnout, depression, anxiety, anger, anhedonia, insomnia, poor relations with others, lack of intimacy, low self-esteem, low self-confidence, poor attention, and overall numbing: physical, emotional, mental, spiritual, and interactional.

Treatment

Treatment issues related to workaholism include the need to learn new forms of self-care through body-mind awareness, develop healthy work boundaries with time and energy, and learn how to engage in social outlets. The counselor can support the client in developing a new relationship to self through creative dialogue, experiential assignments, and meditation techniques. Group support can be found in many communities through Workaholics Anonymous and Alanon. In Alanon, clients may be able to identify their needs to control others, to overextend themselves to please others, and to avoid emotions by focusing on others. A resource for more information about work addiction is the book *Work and the Evolving Self: Theoretical and Clinical Considerations* (Axelrod, 1999).

Other Considerations

In comparing assessment of substance addictions with assessment of related addictive disorders, it is clear that there are many similarities. This is also true of the many other process addictions which include addictions to religious, exercise, rage, power, and more. Appropriate interviewing techniques need to be pursued to determine the following factors regarding the relationship a client has to a substance or activity: (1) intention or motivation;
(2) physical, mental, emotional, social, and spiritual benefits;
(3) how much time and thought is dedicated to the substance or activity;
(4) how long ago the behavior began and under what circumstances; and
(5) whether or not the client has been able to consistently control the use of the substance or activity.

Awareness of clients as individuals, and their individual perceptions of these factors, will assist counselors in understanding unique symptoms of tolerance, withdrawal, dependence, and negative consequences for each

without making assumptions that can be damaging.

The "healing" process may peel away "layers of the onion" and clients may have to face many addictions in long-term recovery. Counselors need to be aware that substance addictions may develop last in a chain of addictive processes, and that clients may revert to previous coping strategies such as eating disorders that were present long before the first drink or drug was ingested. Other addictions may be concurrent with the most obvious one, or they may arise during times of stress as older coping strategies surface. Clients might switch addictions as a defense mechanism and it is important for counselors to assist clients in addressing core issues. A trap to avoid is focusing on symptoms and actually enabling clients to rely on addictions as coping skills. Because the core issues relate to events, beliefs, and cognitive patterns, a cognitive/behavioral approach is an effective counseling method when working with clients who have addictive disorders. Clients benefit from cognitive restructuring and relapse prevention planning. Substance abuse relapse prevention plans can be adapted for working with other addictions. As the client increases healthy coping skills, engages in supportive family and community support, and begins to balance the body/mind/spirit/environment/relationship in daily living, symptoms and relapse compulsions subside.

When treating a client with multiple addictions, it is important to prioritize treatment issues beginning with the most life-threatening first. Psychiatric issues other than addictions must be considered in the process of treatment planning and implementation as well. One of the challenges is sorting out what is most life-threatening when a client presents with multiple forms of self-destructive behavior. In early recovery symptoms of addictions can disguise other mental health issues such as sexual acting out can also be associated with borderline personality disorder, bipolar disorder, or a history of sexual abuse with poor boundaries and current dissociation. Clinicians can develop the ability to distinguish between characteristics of dependent personality disorder, symptoms from being involved in an abusive relationship, and codependency in the role of the enabler/ fixer/controller. In almost every case, clients are faced with challenges in relationships and must address some level of codependency. Ultimately, the challenge of addiction recovery for any individual is reduced to working on issues of relationships to self and others. Melody Beattie's book *Codependent No More and Beyond Codependency* (1997) is a resource for more information on codependency.

When clients are unable to provide an accurate history or current information, and have given permission through appropriate releases, clinicians can enlist family members in completing the assessment process. Family members also suffer consequences of addiction and, if not treated, may contribute to a family member's addiction through enabling behaviors. Additionally, there are usually multiple factors contributing to addictive processes, so obtaining updated and/or previous medical and mental health records on the client may assist in diagnosis. Important information to obtain are records from recent hospitalizations including discharge summary, psychiatric evaluation, history and physical exam notes, and the last two days of chart notes.

A final issue to address is that of treatment and managed care. Managed care companies recognize the need for treatment based on *medical necessity*. It is up to the counselor, health care team members, or another qualified representative to advocate for the client by using medical necessity terms that will be recognized as meeting medical necessity criteria by insurance companies, managed care representatives, and utilization review specialists. This can be challenging because the rules constantly change. It is not likely that insurance will cover treatment for disorders that do not appear to be immediately life-threatening. There are also inconsistencies between what is considered medical and what is considered mental health, therefore insurance will honor the policy according to medical benefits versus mental health benefits. For example, a person with anorexia nervosa may be malnourished and need in-patient medical intervention for re-feeding. The managed care company might list the diagnosis of anorexia nervosa as psychiatric, therefore denying medical benefits, or as medical and deny psychiatric benefits. In another possible scenario with a person who uses substances to deal with the shame of an underlying sex addiction as well as chronic depression with suicidal ideation, the managed care company might recognize the need for a 1- to 5-day in-patient stay for detoxification and/or depression. The same company might not recognize the need for group therapy, in- or out-patient, to address the sexual addiction because it is not classified in the DSM-IV. One of the best ways to advocate for a client can be to refer for a psychiatric evaluation with an addictions medicine specialist who can determine the medical need of the client. Again, the counselor can best serve the client by working with a team of professionals to determine treatment planning and implementation.

Summary

In this chapter, an overview of related addictions has been provided. Basic information, prevalence, diagnostic criteria, assessment tools, and treatment issues have been provided for eating disorders, compulsive gambling, sex addictions, and work addiction. Addictions can be seen on a continuum from experimentation to dependence and it is important for counselors to be aware of the symptoms along this continuum. Many individuals with addictions adopt coping strategies by exchanging one addiction for another or by engaging in multiple addictive processes simultaneously. Individual therapy, group therapy, self-help group support, medications, exercise, nutrition, relaxation, recreation, spirituality, and healthy relationships are all critical factors in addiction recovery. It is important to engage family members in the client's recovery process for relapse prevention purposes.

There are professional counselors, psychiatrists, and treatment centers who specialize in the diagnosis and treatment of these different addictions. Counselors can contact credentialing organizations to locate specialists. A resource for physicians specializing in addictions medicine is the American Society of Addiction Medicine (ASAM), who can be reached at 301-656-3920 or email@asam.org. ASAM members whose backgrounds are extensive in addictions medicine are specialists in substance addictions, not necessarily in other addictions. Another resource is Sierra Tucson, an in-patient dual-diagnosis treatment/psychiatric facility in Arizona treating all addictive disorders. Sierra Tucson has a national data base of specialists and can be contacted at 800-842-4487 for referrals and treatment information. Other information sources are conferences, symposiums, workshops, or on-line conferences that can be located by contacting credentialing organizations, state counselor certification boards, and internet web pages.

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Related Addictive Behavior

Tina Buck & Amos Sales

Rationale

Addictive disorders other than those to alcohol, tobacco, and other drugs are prevalent in our society and it is common for individuals with substance addictions to also struggle with other addictive processes. Counselors need to understand related addictions for the purpose of supporting clients in maximizing their recovery potential.

Overview

This lesson provides criteria established for different process addictions and includes diagnostic and treatment information that are unique to eating disorders, pathological gambling, sexual addictions, and work addiction. Considerations regarding treatment of multiple addictions, issues related to overlapping psychiatric disorders, insurance and managed care, and referrals for more information are provided.

Objectives

1. To increase awareness of the prevalence of addictive disorders other than substances.
2. To increase awareness of the diagnosis and treatment issues that are specific to eating, gambling, sexual, and work addiction disorders.
3. To practice collaboration with other professionals in developing treatment plans for persons challenged with multiple addictive disorders.

Activities

Exercise I for Objective 1: Prevalence of Other Addictive Disorders

1. Request that students work individually to create a family tree for the purpose of bringing awareness of possible process addictions that are present within their own family systems.
2. Request students keep a journal with weekly entries relating to media representations of relationships to food and body image, gambling opportunities, sexual messages, and work related issues. Suggest that they process their own experiences in these areas.
3. Request that students break into groups of eight to ten and develop a list of high profile individuals who have been identified in the media as having eating, gambling, sex, or work addictions. Have a large class discussion about the stigma attached to each of these people after their addiction became public.

Exercise II for Objective 2: Diagnosis and Treatment

1. Request that students break into four small groups for the purpose of discussing the diagnostic criteria for the four areas covered in this chapter: eating, gambling, sex, and work addictions. Ask each group to discuss the diagnostic criteria for each area, to brainstorm about what substances clients engaging in each area may abuse and why, and then present to the large group their findings.
2. Request students examine the similarities and the differences between substance addictions and related addictive disorders. In a large group discussion, request that they discuss what they imagine the similarities and differences are between treating substance addictions and related addictive disorders.

3. Request that the students break into four small groups, assigning each group one of the related addictive disorders, and have them brainstorm about possible triggers that are unique to each area, and how they would work with clients in a relapse prevention plan to deal with those triggers.

Exercise III for Objective 3: Developing a Treatment Plan

1. Break the class into two groups and have each group assign roles to group members that represent a multi-disciplinary treatment team consisting of a counselor, case manager, psychiatrist, psychologist, family therapist, as well as developing a role that will benefit the team in making treatment decisions specific to their client example. Assign each group one of the following client examples and have them collaborate in developing a treatment plan that is appropriate to the needs of the case.

Client Example

Tania is the youngest in a family of four children. Tania's mother was obese and a chronic dieter. She relied on Tania as her "overeating companion" and placed Tania on her first diet at the age of eight. Tania had mixed messages from her family of origin concerning food and body image. During early adolescence Tania was date raped and became depressed. Shortly after this incident she began reading about nutrition and health in magazines and started refusing to eat foods that had any fat content. Tania stayed busy with sports activities in school and regularly skipped meals. Tania wore baggy clothing and often made negative comments about her body to others. Around the age of 17 she learned how to purge and engaged in this behavior after most meals in addition to using laxatives. Her intake of food began to fluctuate and she went through periods of fasting alternating with other periods during which she ate copious amounts of soft foods such as peanut butter and oatmeal after which she purged. She thought about her body image over 70% of her waking hours. During her freshman year in college, Tania began having posttraumatic stress disorder (PTSD) symptoms from the date rape trauma and began using crystal methamphetamine intravenously. She sought help for her eating disorder when she produced failing grades during her first sophomore year and began experiencing suicidal ideation. During her assessment, she reported daily symptoms including use of one box of laxatives, purging up to three times, and participating in two hours of aerobic exercise, and weekly use of between two to three grams of crystal methamphetamine.

Client Example

At a young age, Jeffrey was repeatedly molested by a babysitter over a two year period. After this, he began masturbating in private and, at times, in the classroom. He was told that the behavior was evil and that he was a bad boy who should know better. To cope with his shame, Jeffrey began overeating and began a lifetime problem with obesity. As Jeffrey got older he began using pornographic material to enhance his sexual experience and, over time, began objectifying women and fantasizing about sexual encounters with women with whom he worked. He began smoking cigarettes in an attempt to control his weight. Jeffrey lost several jobs for repeatedly spending time away from his desk job while masturbating in the company restroom and visiting local peep show during extended lunch breaks. Jeffrey's monthly phone bill amounted to an average of $2300 from calling area code 900 pay-per-minute sex lines. His sexual addiction progressed: when on a new job, he had Internet access and was confronted for masturbating while accessing online pornography at his desk. After losing this well-paying job he began stock market and commodities trading from his home computer, as well as gambling on Internet sites. Jeffrey spent an average of 19 hours per day on the Internet, fluctuating between work related, gambling and pornography sites and chat rooms. He reached a bottom with his addictions after developing a painful case of repetitive strain injury in both arms, wrists, and hands from excessive typing and sought help through a walk-in counseling clinic. During the assessment, he disclosed being 150 pounds overweight, smoking two packs of cigarettes daily, and having approximately $75,000 in gambling debt.